Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS146S	A. BUILDING _____ B. WING _____	03/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH TRANSITIONAL REHABILITATION CE	2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on February 25, 2010 and finalized on March 2, 2010 in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00024422 was substantiated with a deficiency cited. (See Tag Z230) Complaint #NV00024388 was unsubstantiated. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiency was identified:	Z 000		
Z230 SS=D	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z230	Continued From page 1 psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on observation, interviews and record review, the facility failed to have a sufficient number of slings available to transfer residents out of bed with a Hoyer lift at the time of resident's request. (Resident #1) Severity: 2 Scope: 1	Z230		